mental health services IN ALBERTA

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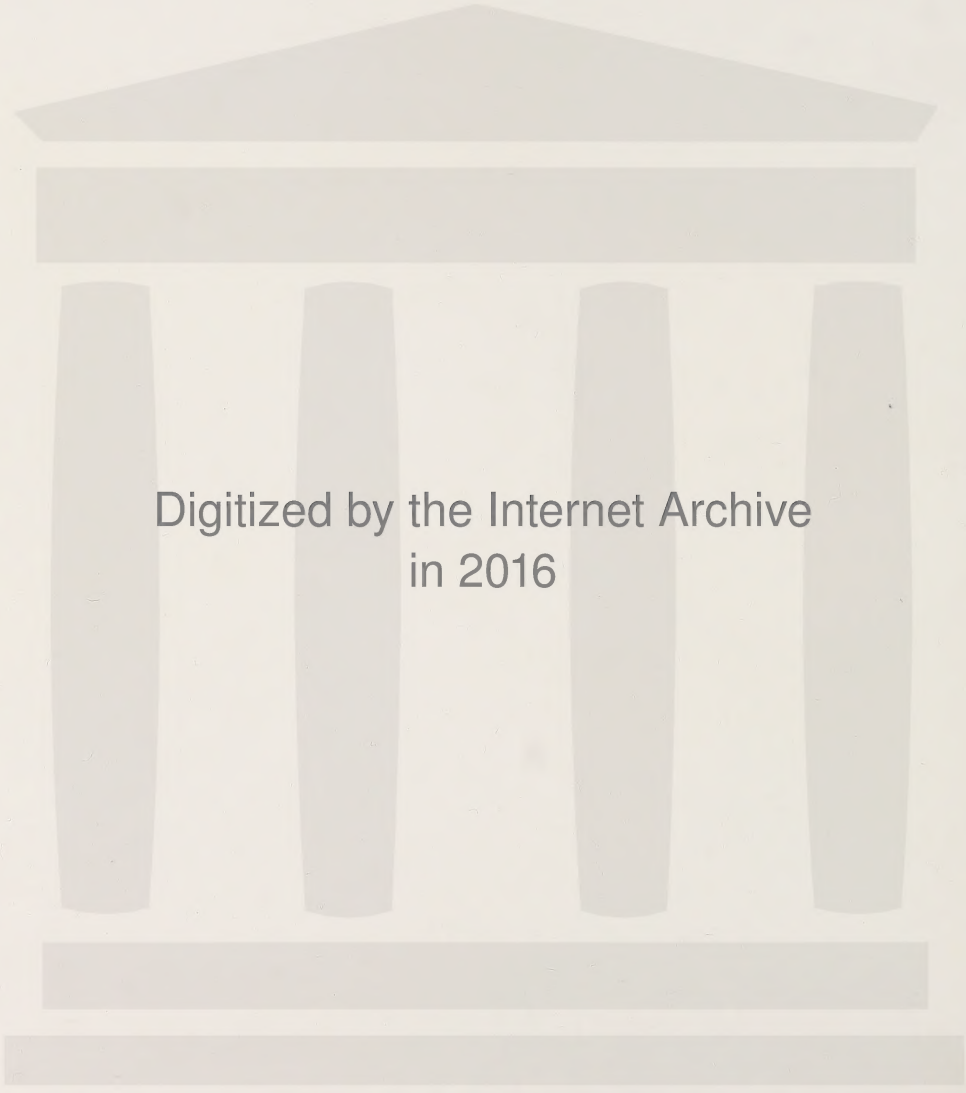
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Mental Health Services in Alberta

November 1988

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Purpose of the Paper

The purpose of this paper is to outline an overall policy direction which can be used to guide program development for mental health services in Alberta.

The paper describes the current mental health service delivery system, lists general principles for the development of services, and proposes a model for service delivery. This model is consistent with the government's Statement of Social Policy: Caring and Responsibility. Finally, the paper describes major issues affecting mental health services in Alberta, and outlines recommended goals and proposed actions relating to these issues. The goals and actions are presented in broad terms. If they are approved, further work would be undertaken to formulate detailed strategies for their implementation.

The contents of this paper are for discussion purposes.

I. Introduction and Background

In 1967, the Alberta Government commissioned a study on mental health care in the province. The study was undertaken by a committee chaired by Dr. W. Blair. The resulting report, *Mental Health in Alberta: A Report on the Mental Health Study*, contained 189 recommendations. The report, approved in principle by the Alberta Government, advocated deinstitutionalization of services for the mentally ill, discouraged expansion of long-term psychiatric hospitals, and advocated a shift in the provision of acute psychiatric services to psychiatric units in public general hospitals. The Blair Report, as it was commonly referred to, set the stage for a significant phase in the evolution of Alberta's mental health services system.

In November 1972, the Mental Health Act was passed. Cited at the time as progressive legislation, it is still effective today. Since then, the Alberta Government has continued its commitment to progressive mental health legislation. Most recent evidence of this was the commissioning of the Drewry Task Force in 1982. The Task Force Report, received in December 1983, resulted in an extensive review of the Mental Health Act. A new Mental Health Act was passed during the Spring 1988 Session of the Legislature. The Act is anticipated to be proclaimed in 1989. The new Act recognizes the Canadian Charter of Rights and Freedoms as well as changes in mental health practice in recent years.

Much, however, was accomplished in the previous decade. For example, the start on deinstitutionalization was made in the early 1970s. This has now seen the number of beds in the province's two mental hospitals — Alberta Hospital Edmonton and Alberta Hospital Ponoka — drop to 1072 today from approximately 2000 in the 1970s. (In 1982, management of these two hospitals was handed over to appointed boards. This enabled the hospitals to reaffirm their commitment to quality acute psychiatric care.)

Also in the 1970s, mental health services in general hospitals were expanded significantly. Inpatient and outpatient programs were instituted in all major urban hospitals and in each regional hospital. Community mental health services were formalized, using as their foundation the then-existing guidance clinics and community nursing services. The network of community mental health clinics now extends throughout the province. Clinics are in place in 56 locations, providing services to children and adults.

The Alberta Government also established a Provincial Mental Health Advisory Council and Regional Mental Health Councils to identify mental health issues and advise the Minister on areas of concern. Alberta is the only province with a full-time suicidologist and a Suicide Prevention Provincial Advisory Committee.

More recently, the government has reduced the number of beds in the Extended Care Centres and developed outreach and day programs in these facilities. A major commitment has been made to completely redevelop Alberta Hospital Ponoka, including the addition of a specialized brain injury unit.

Alberta has excelled in mental health services in other ways. In 1980, Premier Peter Lougheed received the Canadian Mental Health Association

Award for Significant Achievement in Mental Health, specifically because Alberta was the first province in Canada to establish a fully accredited community mental health service. The Helen Hunley Forensic Pavilion, which opened at Alberta Hospital Edmonton in 1982, is the most modern and best designed forensic facility in Canada. As well, the province's forensic service is comprehensive, with outreach services to the community and to correctional facilities. This service was expanded in 1986 to accommodate young offenders in a new inpatient unit located in the Helen Hunley Forensic Pavilion.

The establishment of Psychiatric Services Planning Committees in all regions of the province in 1984 has led to increased coordination and planning by service providers. The government also has recognized the need for preventive services through the funding of Family and Community Support Service programs in communities across the province.

Since the early 1980s, two major reports have influenced planning for mental health services. In late 1980, McKinsey and Company responded to a request from government and completed a report entitled *The Challenge for Psychiatric Care in Edmonton and Northern Alberta — An Action Program for the 1980s*. In January 1983, the Clarke Institute of Psychiatry was commissioned to report on its findings in the *Southern Alberta Study of Psychiatric Needs and Provisions*.

Both studies built on the recommendations of the Blair Report, but emphasized issues which had not yet been resolved. Issues addressed in these reports included coordination of services, strengthening of interdepartmental linkages, and the need for coordinated and systematic planning for services for specialized groups. In the context of the recent Statement of Social Policy: Caring and Responsibility, work must continue on these issues to ensure that Alberta maintains its standards of excellence in mental health care.

II. Description of Mental Health Services in Alberta

Mental health services in Alberta are delivered through government departments, hospitals, funded agencies and private practitioners. The major responsibility rests with Alberta Health. Other government bodies involved include Alberta Education, Alberta Solicitor General, Alberta Social Services and the Alberta Alcohol and Drug Abuse Commission (AADAC). Coordinator of their activities is the Interdepartmental Committee on Mental Health. This is composed of senior officials of the departments. Citizen input is obtained through a number of advisory committees.

Here are the constituents of the province's mental health delivery system, together with their services and responsibilities. They are shown as a chart in Figure 1 on page 6. The blend of government-operated, board-governed and private services ensures accessibility to basic mental health services. At the same time, it encourages communities to respond to local needs.

ALBERTA HEALTH

- Community Outpatient Mental Health Clinics: outpatient assessment, diagnostic and treatment services through 56 permanent mental health clinics and about 44 travelling clinics servicing rural areas.

- Extended Care Centres: inpatient, long-term care and treatment for chronically mentally ill adults through three institutions: Claresholm Care Centre, Raymond Care Centre, and Rosehaven Care Centre.

- Funded Agency Programs: funding to individuals and 58 agencies (32 residential and 26 non-residential) to provide community residence, day programs or support services for people in the community with mental disorders.

- Suicide Prevention Program: the provincial suicidologist develops and is a consultant to suicide and crisis programs.

- Mental Health Hospitals: two board-operated hospitals — Alberta Hospital Edmonton and Alberta Hospital Ponoka — deliver active treatment for psychiatric patients. Both hospitals also provide rehabilitation and psychogeriatric services. Alberta Hospital Edmonton operates the provincial Forensic Service; Alberta Hospital Ponoka has Substance Abuse and Brain Injury programs.

- General Hospital Psychiatric Programs: 16 general hospital units in the province offer shorter-term treatment for inpatients. Outpatient service is also provided.

- Alberta Health Care Insurance Plan (AHCIP): this makes payments to physicians and psychiatrists, primarily for outpatient therapy.

ALBERTA ALCOHOL AND DRUG ABUSE COMMISSION (AADAC)

- Residential Programs: 27 programs provide inpatient detoxification, treatment, shelter, or residential halfway house services.

- Outpatient Programs: 35 programs provide outpatient services. Programming includes 256 residential/halfway house beds.

FIGURE 1

SERVICE DELIVERY IN ALBERTA

DEPARTMENTS WITH MAJOR RESPONSIBILITIES

HEALTH

Psychiatric Hospitals
Alberta Hospital Edmonton
Alberta Hospital Ponoka

General Hospital Psychiatric Programs

AHCIP (See Private Practitioners)

Community Outpatient Mental Health Clinics

Extended Care Centres

Funded Agencies
(Residential and Day Programs)

Suicide Prevention Program

OTHER DEPARTMENTS

SOCIAL SERVICES

Assessment and treatment services to Child Welfare clients provided directly, by contract with private practitioners or through Alberta Mental Health Services. Some direct services provided in both child and adult residential facilities.

EDUCATION

School counsellors and school psychologists provide academic and career counselling and assessment.

AADAC

Residential Programs

Outpatient Programs

SOLICITOR GENERAL

Ensures that assessment and treatment services are provided for offenders in custody or in community corrections programs. Some direct services provided in correctional institutions.

OTHER GROUPS

PROFESSIONAL/CITIZEN GROUPS AND COMMITTEES

Provincial Mental Health Advisory Council

Regional Mental Health Councils

Suicide Prevention Provincial Advisory Committee

Regional Psychiatric Services Planning Committees

PRIVATE PRACTITIONERS

Physicians and psychiatrists paid through AHCIP for psychiatric services.

COMMUNITY SUPPORT

Clergy
Self-help groups
Volunteers

ALBERTA SOLICITOR GENERAL

- Ensures provision of services for assessment and treatment of young and adult offenders in custody, and for those in community corrections programs. Provides some direct services in correctional institutions.

ALBERTA EDUCATION

- Supplies academic and career counselling and assessment by school counsellors and psychologists.

ALBERTA SOCIAL SERVICES

- Provides, or purchases, assessment and treatment services for its departmental clients. Most services are for children in need of protection and their families. Included are mental health services within department-operated and contracted residential treatment facilities for children and adolescents who are Child Welfare clients. In addition, services for the adult handicapped do incorporate mental health components.

PROFESSIONAL/CITIZEN GROUPS AND COMMITTEES

- Citizen representation is secured through the Provincial Mental Health Advisory Council, the Regional Mental Health Councils, and two mental health hospital boards established under the Mental Health Act. Psychiatric Services Planning Committees also exist in all regions.

PRIVATE PRACTITIONERS

- These are physicians and psychiatrists who provide psychiatric services and are paid through the Alberta Health Care Insurance Plan (AHCIP).

COMMUNITY SUPPORT

- This includes counselling, self-help and other support from organized and volunteer services.

SUMMARY OF DATA ON THE DELIVERY OF MENTAL HEALTH SERVICES

Appendix 1, starting on page 21, contains three tables of data on mental health service delivery.

Information provided herein reflects the data available when the departments of Hospitals and Medical Care and Community and Occupational Health were separate entities prior to their amalgamation in September 1988.

Table 1 provides a breakdown of the total mental health services budget for the 1986/87 fiscal year by delivery system. This shows that, of the year's budget of $228 million, 63.7% came under the jurisdiction of Alberta Hospitals and Medical Care, 18.6% under the jurisdiction of Alberta Community and Occupational Health. A further 8.6% was allocated to other government departments; the remaining 9.1% comprised payments made to private practitioners.

Table 2 provides a breakdown of the 1986/87 budget by service type. Here, institutional services accounted for 76.8% and community services for 12.7% of the $228 million budget. The remaining 10.5% included the budget for Alberta Solicitor General and payments made to private practitioners.

Table 3 shows the number of beds or spaces in use for mental health patients during the 1986/87 fiscal year, as well as the number of inpatients and outpatients served. The beds per population ratio for Alberta has been decreasing slightly since 1984. However, the 1985/86 ratio of 1.39 beds per 1,000 population was marginally higher than the Canadian average of 1.32 per 1,000.

III. General Principles

PRINCIPLES

The general principles proposed to guide development and delivery of mental health service delivery in Alberta are as follows:

1. Effective mental health services require a partnership among the family, the community and the government. These services rely on appropriate support systems (family, residential, educational, employment, financial, social and recreational) to enable individuals to live full and productive lives.

2. A continuum of services will be made available through collaboration of service providers, and as resources permit.

3. The mental health system should maintain and strengthen individual, family and community resources.

4. Mental health services should facilitate independence and respect personal lifestyle.

5. The mental health system should provide care at the least intrusive level consistent with clients' needs.

6. Financial incentives should encourage the client and service providers to use the least intrusive service(s).

7. Focus of care, where hospitalization has been required, should be to take all steps that are necessary to use community-based rather than institutional services and return clients to the community as soon as possible.

8. The mental health system should, where feasible, foster self-sufficiency by encouraging individuals to accept responsibility for their mental health; where necessary, it should assist clients in choosing services required to maintain and restore their mental health.

IV. A Model for Mental Health Service Delivery in Alberta

The proposed principles furnish a sound base for creating the model for delivery of mental health services in Alberta. The model is described on this page and illustrated in **Figure 2** on page 11. It addresses seven needs or issues:

- A **continuum of care** emphasizing the least intrusive level consistent with client need, and with a bias toward the use of community services.
- **Coordination** among the mental health services in the continuum and the strengthening of links among the various services.
- Establishment of **overall service priorities** and **allocation of resources** consistent with these priorities.
- Integration of the principles of **prevention and promotion of mental health** at all levels in the continuum of care.
- Retention of a **multidisciplinary approach** in the provision of mental health services.
- Integration of and **sharing of information** regarding mental health services.
- Recognition of the unique needs of **special groups** for services at all levels of the continuum.

Within the model, the client should have access to services which can be grouped into five components, ranging from least to most intrusive. Each component would have the capacity to provide specialized services to various groups, such as children, elderly, and the chronically mentally disabled. Regardless of where a client accesses services, the importance of appropriate support systems (family, residential, education, employment, financial, social and recreational) would be addressed.

Here are the five components of the model. The major groups are ordered from least to most intrusive, though this does not apply to individual services within the groups.

Preventive Programs

- general mental health promotion
- prevention for high-risk target groups

Community Support Network

- counselling
- information/referral
- self-help groups
- social agencies
- educational and vocational services
- residential
- financial services
- recreational services

Community Health Services

- public health nursing programs
- home care programs
- care by family physicians
- services from private practitioners; e.g., psychologists

Organized Mental Health Treatment Services

- mental health clinics
- hospital outpatient programs
- hospital and community day programs
- residential treatment programs
- psychiatrists and other professionals in private practice

Inpatient Services

a) acute (short term)
b) long term

RELATIONSHIP OF COMPONENTS

Figure 2 illustrates the five components of the model and their relationship to each other.

The left side of the figure represents entry into the mental health system; the right side represents post-entry activity within the system, leading to discharge.

The density of the boundary line between any two components represents the ease or difficulty of moving from one to the other. The heavier the boundary line, the more stringent are the criteria. For example, once the client has entered the sytem (the left-hand side of the figure), the boundary lines become heavier — the criteria become more stringent — as the client moves from "Preventive Programs" toward "Inpatient Services". The reverse is true on the right-hand side of the figure. Here, the boundary lines become lighter as the client moves away from the centre.

GEOGRAPHICAL CONSIDERATIONS

It may not be feasible to provide all levels of service, from generic to specialized, in all areas of the province. It is proposed that specialized services would generally be located in urban or regional settings rather than in rural areas.

In broad terms, three different levels of service would be provided. The different levels of service can be described as follows; they are depicted in **Figure 3** on page 12:

Generic — access within a reasonable distance to a mental health worker, a physician and to general hospital care for the purposes of addressing a mental health concern.

Regional — access to a psychiatric program and community residential services with some specialization for various groups (as resources permit), in addition to the generic service mentioned above.

Specialized — access to specialized services for all groups (as resources permit).

Figure 2
Relationship of Model's Five Components

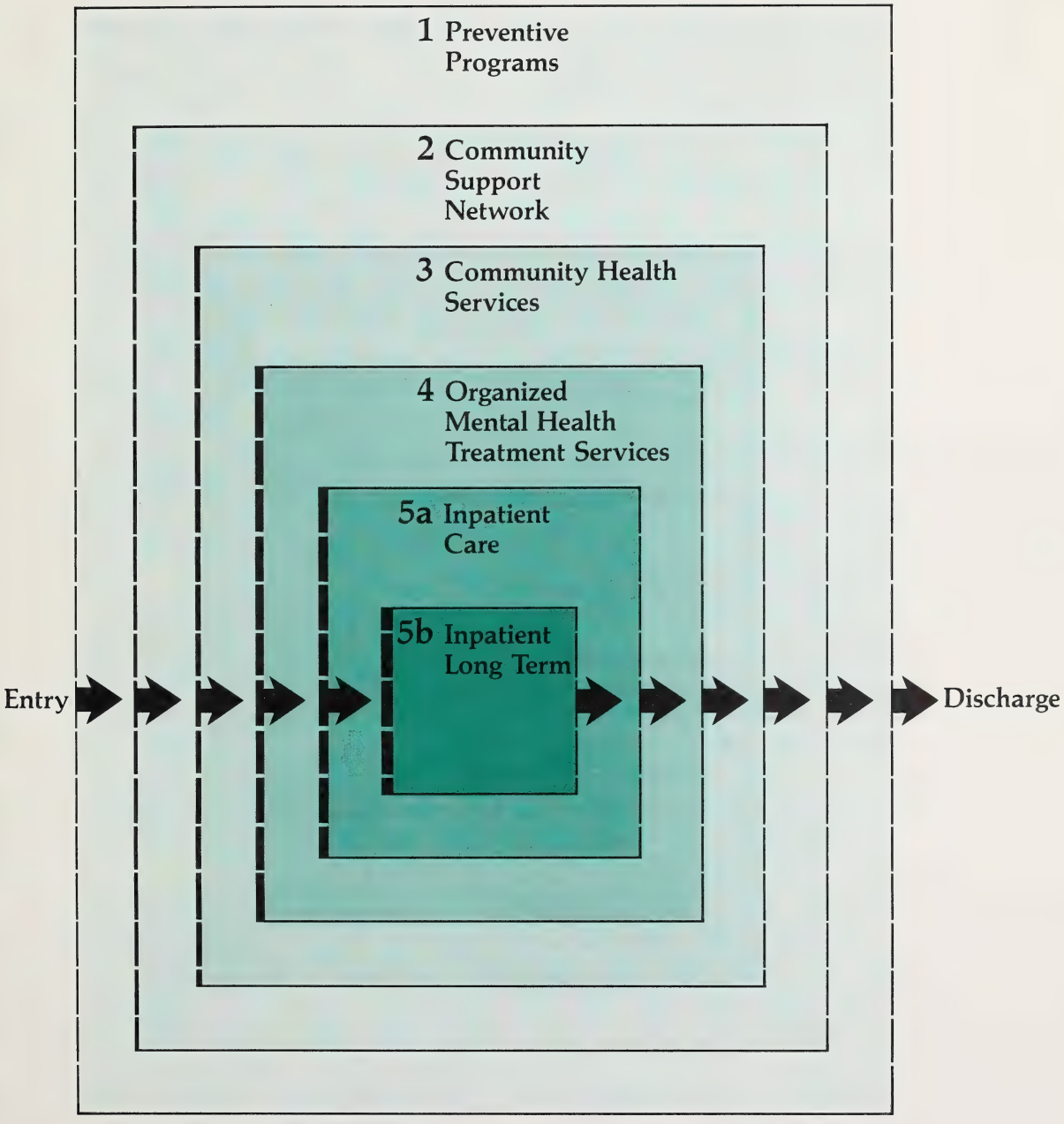
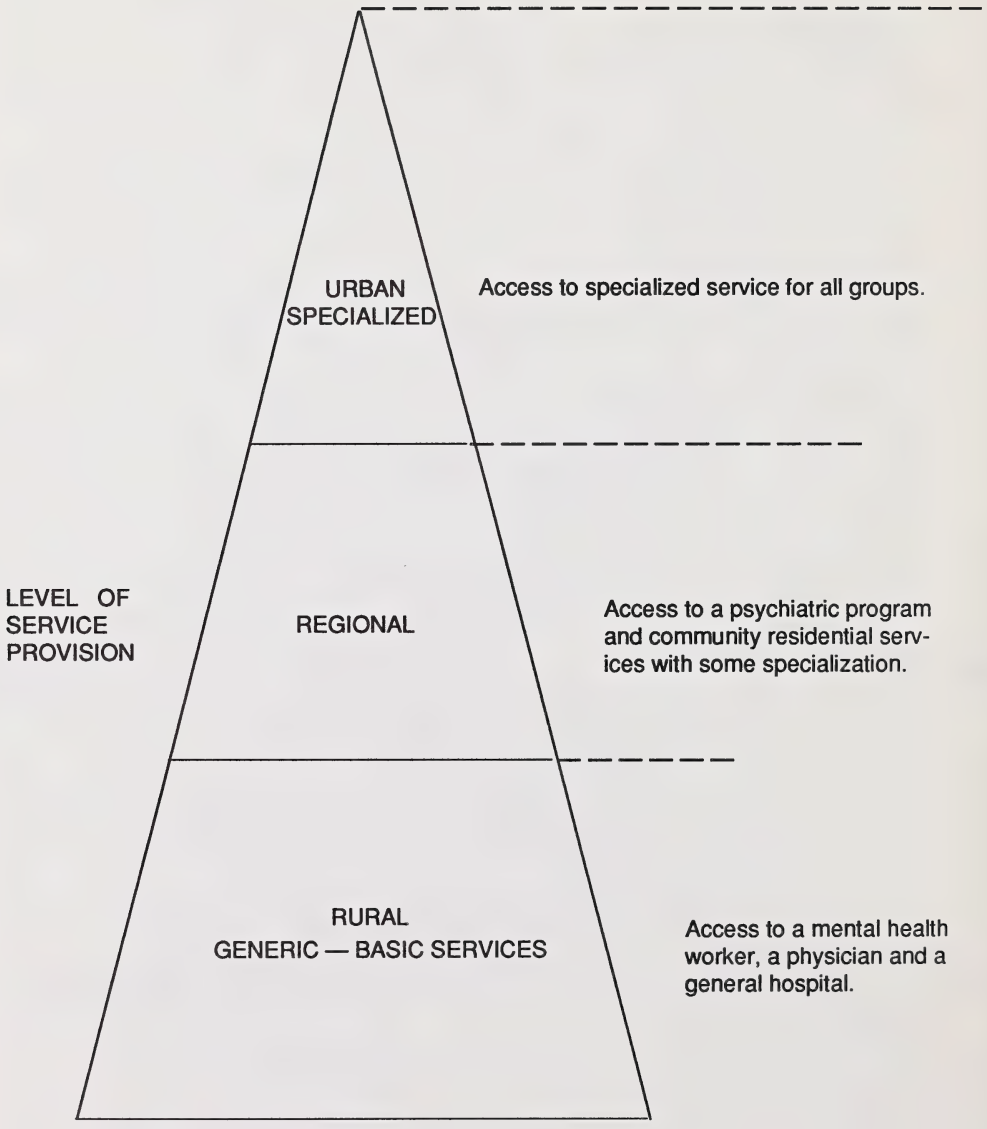


FIGURE 3

LEVELS OF SERVICE RELATED TO GEOGRAPHICAL LOCATION



V. Issues Affecting the Future of Mental Health Services in Alberta

Seven major issues have been identified that affect the future of mental health services in Alberta. Broadly speaking, they parallel the list of needs addressed in the model, and shown on page 8.

- Continuum of Care
- Service Coordination
- Service Priorities and Allocation of Resources
- Prevention and Mental Health Promotion
- Staffing and Recruitment
- Information Systems
- Services for Special Needs Groups

In this section, each issue is briefly described, and the goals and proposed actions pertaining to it are outlined.

CONTINUUM OF CARE

Definition of Issue

Currently, the range of mental health services includes community/non-institutional services, institutional/hospital services, and community services aimed at clients following discharge. Clients enter at any point along the continuum and may not necessarily access the least intrusive services.

With the increasing shift toward community care and the current demand for service, community services should receive first consideration for any additional funds.

Goals

a) To ensure the least intrusive care consistent with quality clinical care and client need.

b) To increase use of a range of community services as an alternative to hospitalization.

c) To increase the institutional sector's provision of some community-based mental health services; for example, day treatment programs.

d) To emphasize community services as the first point of entry to the system.

e) To facilitate movement from one level of service in the continuum to another, where appropriate, emphasizing least intrusive intervention.

f) To identify and eliminate gaps and duplication in service delivery.

Proposed Actions

a) Make the general public aware of the community mental health services which exist as alternatives to hospitalization.

b) Encourage health care professionals, including physicians, to use the broad range of community services

which offer alternatives to hospitalization.

c) Affirm the mandate of the Regional Psychiatric Services Planning Committees in coordinating and planning services.

d) Encourage hospitals to become involved in providing community-based programs; for example, day treatment programs. Through special incentives, such programs should support early discharge from inpatient status and minimize admissions.

e) Fund community agencies to enable them to provide community mental health services responsive to local needs. Also, encourage Family and Community Support Services to expand services in community mental health programming.

f) Ensure that funding for mental health services is consistent with the principles listed in Section III on page 8.

SERVICE COORDINATION

Definition of the Issue

As described in Section II, mental health services are delivered through a number of government departments, hospitals, funded agencies, private practitioners and volunteer organizations. With the recent trend toward deinstitutionalization, the need has increased for coordination between community and institutional services. The aim is to enable clients to receive a broad range of services appropriate to their needs and ensure that gaps in the continuum of care are minimized.

Goals

a) To improve coordination between hospital inpatient, outpatient and community services, especially following discharge.

b) To make good use of coordinating mechanisms now in place, such as the Interdepartmental Committee on Mental Health, and the Regional Psychiatric Services Planning Committees.

Proposed Actions

a) Ensure that coordinating mechanisms (such as Regional Psychiatric Services Planning Committees) are in place throughout the province, and affirm their mandate.

b) Require that all proposals for funds for new initiatives be reviewed by the Regional Psychiatric Services Planning Committees. The expectation is that these committees will undertake joint planning for services within their own regions.

c) Encourage coordinating strategies such as cross-appointments, space sharing, and joint contracts between service providers.

SERVICE PRIORITIES AND ALLOCATION OF RESOURCES

Description of the Issue

Currently, each service provider plans services independently and determines its own priorities. Resources are allocated on a service-by-service basis rather than as part of an

overall plan. Service priorities and resources may also vary by geographical location: urban, regional and rural.

Goals

a) To ensure that mental health service priorities are clearly stated.

b) To clarify expected levels of service provision according to geographical location.

c) To ensure that planning and resource allocation are consistent with stated service priorities.

Proposed Actions

a) Assign priority to the following target groups: children and adolescents, chronically mentally disabled, and the elderly.

b) Support the further development of a continuum of care by increasing:

- community/family/home support services
- emergency/crisis intervention services
- day treatment programs
- community residential services
- sheltered employment and vocational rehabilitation programs.

c) Encourage planning for regional services and allocation of resources according to established provincial priorities through the Regional Psychiatric Services Planning Committees.

d) Communicate expected levels of service availability to Regional Psychiatric Services Planning Committees.

PREVENTION AND MENTAL HEALTH PROMOTION

Description of the Issue

It is believed that primary prevention may result in a corresponding decrease in the incidence and severity of mental health disorders, especially when targeted at high-risk groups. More general primary prevention may also be of value. However, government services have historically emphasized the treatment of mental illness more than the prevention of mental disorders or the promotion of mental health. Increased emphasis on prevention and promotion of mental health would complement existing treatment programs.

Goals

a) To develop and aim prevention programs at specific target groups such as children of psychotics, battered wives and children, and the unemployed.

b) To increase support for development and provision of prevention and health promotion programs for the general population.

c) To determine through research the effectiveness of prevention programs in mental health.

d) To ensure coordination with the federal government's prevention programs.

Proposed Actions

a) Identify target groups and specific interventions which could be the focus of prevention programs.

b) Provide funding incentives to private agencies and organizations to provide generic mental health promotion programs.

c) Encourage education authorities to provide programs in prevention — especially suicide prevention — within the school system.

d) Encourage and support research activities in the prevention of mental illness.

e) Ensure coordination with the federal government's prevention activities, so that all activities are complementary.

STAFFING AND RECRUITMENT

Description of the Issue

Shortages of personnel within professional groups, difficulties in recruiting to rural areas, and the changing demands within the mental health system result in staffing and recruitment problems for service providers. In particular, there is currently a shortage of professionals with expertise to deal with special needs groups such as children, adolescents, the elderly, natives, mentally handicapped and offenders.

Goals

a) To ensure that qualified professionals are available to meet the needs of the various services and special needs groups at all levels of the continuum.

b) To maintain a multidisciplinary approach in the provision of mental health services.

Proposed Actions

a) Encourage universities and other post-secondary institutions to incorporate mental health training into their existing curricula.

b) Develop effective recruitment strategies to minimize the impact of staff turnover and vacancies, especially in rural areas.

c) Encourage service providers to work together in recruiting staff.

d) Ensure that specialized training is provided to allow professionals to work effectively with special needs groups.

e) Increase the use of consulting psychiatrists in rural Alberta.

f) Examine the feasibility of utilizing telecommunications to provide services to remote areas.

INFORMATION SYSTEMS

Description of the Issue

Currently, several freestanding mental health information systems exist, operating with different priorities, data bases, data entry policies and procedures. If they could be more effectively coordinated, joint service planning would be more easily effected.

Goals

a) To integrate existing information systems, thereby creating a uniform system which would provide accurate and timely data on client flow, service provision and cost.

b) To work toward the development of centralized information.

Proposed Actions

a) Undertake the necessary legal and policy changes to facilitate integration of information systems.

b) Secure agreement among concerned parties on the minimum information requirements for planning purposes.

c) Develop a reporting system which meets requirements for developing policy and programs, and for managing available resources.

SERVICES FOR SPECIAL NEEDS GROUPS

Description of the Issue

Two types of special needs groups have been identified within the mental health system: those defined by their special characteristics and those defined by age.

GROUPS WITH SPECIAL CHARACTERISTICS

Service delivery for all special needs groups is complex, making planning and coordination at all levels extremely important. Groups with special characteristics include, but are not limited to the chronically mentally ill, natives, mentally handicapped, and offenders. Services for these populations require some degree of specialization; however, they must fit within the current mental health system. Yet, if the services for these groups are fully integrated within a general mental health system, their special needs may not be addressed.

- Chronically Mentally Ill

The chronically mentally ill continue to require extensive services. While they receive service in the existing system, the magnitude of their specialized needs must be addressed more fully. Successful deinstitutionalization requires careful planning and service coordination at all levels of the continuum, including day programs, residential options and community support.

- Natives

The uniqueness of native culture, coupled with high rates of suicide, substance abuse and family breakdown, underscores the need for special attention to services for the native population. These special concerns are recognized in the consultation document, Exploring the Circle, which is currently generating discussion among native groups and mental health service providers.

- Mentally Handicapped

Services for the mentally handicapped exist; however, individuals with both a mental handicap and a mental illness have complex needs which require focussed attention. Especially important for this group is collaboration between service providers to ensure that special needs are met.

- Offenders

It has been established that between 15% and 20% of the offender population is mentally ill. Service needs for this group include programs for incarcerated offenders as well as for offenders on probation. Attention to young offenders has increased as a result of new legislation which specifies greater community services. The extent of the needs of offenders exceeds the capacity of the existing mental health system.

GROUPS DEFINED BY AGE

- Children

Emphasis on children's services has increased as a result of the new Child Welfare Act and the Young Offenders Act. These focus on maintaining children with their families in the community. As well, increasing recognition of the importance of early intervention supports the need for more specialized services.

- Elderly

The need for mental health services for the elderly is becoming increasingly important, especially as the elderly population is growing. The proportion of elderly with psychiatric problems is high.

The interaction between the physical and mental well-being of the elderly is especially significant. The need for psychogeriatric care has been clearly identified in pilot projects run in southern Alberta for long-term care services. Although several other initiatives are currently underway, the specialized needs of this group will continue to require attention.

Goals

a) To provide quality generic mental health service which addresses the specialized needs of all age and target groups of clients — children, elderly, chronically mentally ill, natives, mentally handicapped, offenders — at all levels of the continuum.

b) To ensure that clarity exists on the location and definition of prime responsibility within government for services to special needs groups.

c) To ensure appropriate representation from stakeholders in planning for services for special needs groups.

Proposed Actions

a) Clearly assign responsibility for providing services to groups with special needs.

b) Develop programs to recognize special needs within the general mental health delivery system.

c) Ensure that coordination of services for special needs groups is occurring at all levels through established mechanisms, such as the Interdepartmental Committee on Mental Health, and Regional Psychiatric Services Planning Committees.

VI. Policy and Mandate

Definition of the Issues

A number of departments and agencies have responsibility for funding and/or delivering mental health services. However, the organization of these services needs to be aptly structured in order to achieve the overall policy direction set out in this paper, namely that:

a) emphasis be placed on developing community as opposed to institutional care services

b) priority be given to ensuring that services meet the needs of:
- children
- elderly
- chronically mentally ill

c) basic or general mental health services be available within a reasonable distance to all Albertans, with ready referral to more specialized services as required.

Goals

a) To secure the coordination of mental health services at all levels of service delivery.

b) To ensure that priority is given to services for:
- children
- elderly
- chronically mentally ill

Proposed Actions

a) Undertake pilot projects for coordinating mental health services at a regional level through a single authority.

b) Collaborate with communities and interest groups in the development of a provincial plan for the delivery of mental health services.

Appendices

APPENDIX 1
QUANTITATIVE DATA

I. Systems Data

Table 1 Mental Health Services Budget 1986/87, by Delivery System

Table 2 Mental Health Services Budget 1986/87, by Service Type

II. Specific Program Data

Table 3 Mental Health Services 1986/87: Patients Served, by Department

TABLE 1

MENTAL HEALTH SERVICES BUDGET 1986/87, BY DELIVERY SYSTEM

SYSTEM	CASELOAD	COSTS ($1,000's)	TOTAL BUDGET ($1,000's)	PERCENTAGE OF BUDGET
HOSPITALS & MEDICAL CARE**				
Mental Health Hospitals	3,309	$ 70,161		
General Hospital Psychiatric Programs	8,182	$ 75,184		
AHCIP		$ 20,720*		
TOTAL	11,491		$ 145,345	63.7%
COMMUNITY & OCCUPATIONAL HEALTH**				
Community Outpatient Mental Health Clinics	22,842	$ 16,894		
Extended Care Centres	775	$ 18,194		
Funded Agencies	Not Available	$ 7,410		
TOTAL			$ 42,498	18.6%
AADAC				
Residential Programs	19,303	$ 11,579		
Outpatient Programs	18,009	$ 4,563		
TOTAL	37,312		$ 16,142	7.1%
SOCIAL SERVICES	Data Not Available			
SOLICITOR GENERAL	Unknown	$ 3,314	$ 3,314	1.5%
PRIVATE PRACTITIONERS	Unknown	$ 20,720	$ 20,720	9.1%
EDUCATION	Data Not Available			
GRAND TOTAL			$ 228,019	

* Payments to Private Practitioners (AHCIP) appear twice in the table; however, they are only included once in the Grand Total.

** These departments have merged to form Alberta Health (September 1988).

TABLE 2

MENTAL HEALTH SERVICES BUDGET 1986/87, BY SERVICE TYPE

	BUDGET ($ 1,000's)	PERCENTAGE
INSTITUTIONAL		
Mental Health Hospitals	$ 70,161	
General Hospitals	75,184	
Extended Care Centres	18,194	
AADAC Inpatient Programs	11,579	
TOTAL	$ 175,118	76.8%
COMMUNITY		
Mental Health Clinics	$ 16,894	
Funded Agencies	7,410	
AADAC	4,563	
TOTAL	$ 28,867	12.7%
OTHER		
Solicitor General	$ 3,314	
Private Practitioners	20,720*	
TOTAL	$ 24,034	10.5%
GRAND TOTAL	$ 228,019	100 %

* Payments to Private Practitioners (AHCIP) appear twice in the table; however, they are only included once in the Grand Total.

TABLE 3

MENTAL HEALTH SERVICES 1986/87: PATIENTS SERVED, BY DEPARTMENT

SYSTEM	PATIENT TYPE	BEDS OR SPACES	PEOPLE SERVED ANNUALLY
HOSPITALS & MEDICAL CARE* **			
General Hospitals	Inpatient/ Outpatient	596	11,491
Psychiatric Wards	Outpatient		
Mental Hospitals	Inpatient	1,072 AHE 648 AHP 424	
COMMUNITY & OCCUPATIONAL HEALTH* **			
Extended Care Centres	Inpatient/ Outpatient	Claresholm 200 Raymond 45 445* Rosehaven 200	775**
Mental Health Clinics	Outpatient		22,842
Funded Agencies	Inpatient/ Outpatient	577 Residential 979 Non-residential	Not Available
AADAC			
Residential Programs	Inpatient	864	Treated 19,303 Admissions and Readmissions
Outpatient Programs	Outpatient	35 Programs	18,009

NOTE: Total Outpatient Registrations for 1986/87 for Alberta Hospitals and Medical Care was 154,052.

* Figures are as at March 31, 1987. Deinstitutionalization has seen bed numbers decrease at Claresholm and Rosehaven Care Centre since that date.

** This figure includes inpatients (683) and outpatients (92).

*** These Departments have merged to form Alberta Health (September 1988).

APPENDIX 2 MENTAL HEALTH SERVICES: HOLY CROSS MODEL

The model described here is an example of one unit which stipulates that individuals being referred to inpatient services be assessed for appropriateness for community programs as an alternative to hospital admission.

In the fall of 1980, approval was given by the Holy Cross Administration and the Administration of District #93 to undertake a major review of the mental health services offered at the Holy Cross Hospital. It was hoped that the service delivery model that evolved from this process would encompass a coordinated and integrated approach to the delivery of mental health services and would eventually serve as a plan for a District-wide mental health system.

The following five principles form the basis of the model:

1. **Patient Participation** — ensured through patient involvement with treatment programs and goals, patient feedback and inclusion on planning committees.

2. **Accessibility of Services** — achieved by having one, easy and prompt accessible point of entry into the Mental Health Centre.

3. **Continuity of Care** — involves a Treatment Team which would promote communication, coordination and accountability, and utilize community resources to a maximum. Identification of a primary worker would also be necessary to coordinate and continue patient care.

4. **Complementary Services** — establish criteria for appropriate level of involvement after diagnostic assessment, and provide continuous monitoring and audit. Also, collaboration with community resources in patient management would be important.

5. **Deinstitutionalization** — accomplished by an emphasis on outpatient and community intervention, service provision within a person's own community and active involvement of the Mental Health Centre in the community's identification of needs and service planning.

Clinical services are provided through four multidisciplinary teams: two Outpatient Teams, one Inpatient Team, and one Assessment/Crisis Team, each headed by a Team Director.

Patients are referred by family physicians who have privileges at the Holy Cross Hospital and by staff psychiatrists. Referrals to outpatient services are made through the Assessment/Crisis Team.

A "physician-of-record" is required for every patient referred to the teams. Family physicians usually fill this role providing they have admitting privileges to the Holy Cross Hospital. The physician-of-record is expected to have ongoing involvement with the case for every patient referred. Each patient is assigned to a primary therapist and may be engaged in a number of different therapeutic modalities during the course of treatment.

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